GREENHILL
INSURANCE SERVICES

Mailing Address:
1707 Post Oak, Suite 279
Houston, Texas 77056
WWW.GRNHLL.COM

# Supplemental Questionnaire for Medical Arts Schools

Instructions: Complete this supplement in its entirety. If a specific item is not applicable, please state N/A. If the space provided is insufficient, attach a separate sheet. Please note this supplement is part of the application and all warranties and statements contained therein apply to this supplement.

Name of Insured_____

1. Does insured operate any outpatient/clinic operations?_____

   If **YES**, describe services provided:_____

2. Please provide length of class:_____

3. Enclose copies of each course curriculum.

4. Provide a breakdown of total number of students annually by classification:

   _____#of EMT Basic; _____# EMT Intermediate; _____# Paramedic: _____# LVN; _____# RN,

   Describe other types of students:_____# _____; _____# _____;

   _____# _____;_____#_____; _____#_____.

   Please attach separate sheet if necessary and provide the number of staff / instructors by professional categories.

5. Enclose a description of all externship programs offered and copies of contracts with the facilities where the programs are conducted.

6. If no contracts exist, does insured provide staff instruction to supervise students in the program or does the facility supervise the activities?

_____

_____

_____

_____

Date Applicant Title

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# Professional Liability Application for Health Care Services

**(TO BE COMPLETED ONLY IF A MORE SPECIFIC APPLICATION IS NOT APPLICABLE)**
INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED. If the answer is NONE, state NONE; If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A). If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

## PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): _____

**Tax ID**: _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office (_____)_____ Fax (_____)_____

Email: _____

Website: _____

1.6 Person to contact for Survey: Name: _____Title: _____

Email: _____Telephone Number: (_____)_____

1.7 Year entity established: _____

1.8 The Applicant is (Please check and complete A) or B) below:

☐ A. The **APPLICANT** is an: ☐ INDIVIDUAL ☐ Employee ☐ Student ☐ Sole Practitioner

☐ B. The **APPLICANT** is a: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability

☐ Other –Please Describe _____

1.9 Entity is: ☐ For Profit ☐ Non-Profit

Please describe source of funds: _____

_____

1.10 **Proposed Effective Date:** _____

1.11 Requested Limits of Liability (if available): $ _____/$ _____

1.12 Annual Gross Receipts: Estimated next twelve months - $_____

Last twelve months - $_____

1.13 Annual Remuneration: Estimated next twelve months - $_____

Last twelve months - $_____

1.14 Total Premises Square Footage Occupied By Applicant:_____

## PART II. EXPOSURES

2.1 Service is licensed as _____

2.2 Describe the nature of insured's operation including types of services rendered and activities conducted:

_____

_____

2.3 List all memberships in professional organizations. _____

_____

_____

2.4 Total number of all staff _____

2.5 Number of Professional Staff:

**E = Employed**
**C = Contracted**

| E | C | | E | C | |
|---|---|---|---|---|---|
| ___ | ___ | Aides or Orderlies | ___ | ___ | Optometrists |
| ___ | ___ | Audiologists | ___ | ___ | Opticians |
| ___ | ___ | Chiropractors | ___ | ___ | Paramedics or EMT's |
| ___ | ___ | Dentists | ___ | ___ | Pharmacists |
| ___ | ___ | Dental Hygienists/Tech. | ___ | ___ | Pharmacy Technicians |
| ___ | ___ | Dental Assistants | ___ | ___ | Physicians or Surgeons* |
| ___ | ___ | Dietitians/Nutritionists | ___ | ___ | Physician Assistants |
| ___ | ___ | EEG or EKG Operators | ___ | ___ | Physiotherapists/Physical Therapists |
| ___ | ___ | Electrologists | ___ | ___ | Podiatrists |
| ___ | ___ | Hearing Aid Fitters | ___ | ___ | Prosthetic Device Fitters |
| ___ | ___ | Inhalation/Resp. Therap. | ___ | ___ | Psychologists/Psychotherapists |
| ___ | ___ | Laboratory Technicians | ___ | ___ | RN's |

| | | | | | |
|---|---|---|---|---|---|
| __ | __ | LPN's | __ | __ | Social Workers |
| __ | __ | Medical Technicians | __ | __ | Speech Therapists |
| __ | __ | Nurse Anesthetists | __ | __ | X-Ray or Radiologist Technicians |
| __ | __ | Nurse Midwives | __ | __ | X-Ray or Radiologist Therapists |
| __ | __ | Nurse Practitioners | __ | __ | Other, describe _____ |
| __ | __ | Occupational Therapists | | | |

* Attach list and indicate specialty.

2.6 If you contract for services of any outside health care staff, breakdown total estimated annual payments to contractors and annual estimated Out Patient Visits by professional category. _____

_____

2.7 Do you require:

A) Contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?_____

B) Employed or contracted physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? _____

2.8 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf? ☐ Yes ☐ No

2.9 What minimum limits of Professional Liability are required? _____

2.10 What was your total number of patient/client visits last year? _____

Estimated next year? _____

2.11 Breakdown of patient services:

| | |
|---|---|
| __% Pediatric | __% Gynecological |
| __% Dental | __% Emergency Medical |
| __% Obstetric | __% General Exams |
| __% Psychiatric | __% Occupational Medical |
| __% Rehabilitative Therapy | __% Optometry/Ophthalmology |
| __% Minor Surgery | __% Nutrition (Diet) |
| __% Major Surgery | __% Other(describe) _____ |
| __% Orthopedic | _____ |

2.12 Are any of the following performed?

Administer anesthesia (general or local)? ☐ Yes ☐ No

Surgery (major or minor including Face Peel, Dermabrasion,

Silicone Injection, and Needle Biopsies)? ☐ Yes ☐ No

Cardiac Catheterization ☐ Yes ☐ No
Diagnostic tests ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No
X-Rays ☐ Yes ☐ No
Radiation Therapy ☐ Yes ☐ No
Reduction of Fracture ☐ Yes ☐ No
Shock Therapy ☐ Yes ☐ No
Prescribe medication ☐ Yes ☐ No
Obstetric procedures ☐ Yes ☐ No

For all "yes" answers, please give detailed description on separate page or back of application.

## PART III. RISK MANAGEMENT

3.1 Give name of Administrator/Supervisor and describe his/her training and experience. _____

_____

_____

3.2 Do you enter into contractual agreements? ☐ Yes ☐ No

IF **YES**, please enclose copies of all such contracts.

3.3 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you? ☐ Yes ☐ No

If **NOT**, are you agreeable to instituting this procedure? ☐ Yes ☐ No

3.4 Enclose a copy of all brochures or advertising materials distributed by you.

3.5 Describe any "fund raising" or other special events activities conducted. _____

_____

3.6 Describe any swimming pool, playground or amusement exposure. _____

_____

3.7 Do you rent, sell, or otherwise provide any equipment or products to others? ☐ Yes ☐ No

IF **YES**, complete our Products Supplement.

3.8 Do you provide 24 hour bed and board care for any patients, or do you (wholly or in part) own, operate or administer any facility which does provide such services? ☐ Yes ☐ No

IF **YES**, complete our Residential Facilities Application.

3.9 Do you provide any of the following services?

A) Blood Bank/Plasma Centers ☐ Yes ☐ No

B) Cemeteries/Funeral Homes/Morticians ☐ Yes ☐ No

C) Medical Arts Schools and Colleges ☐ Yes ☐ No

D) Pharmacies ☐ Yes ☐ No

E) Nursing Homes ☐ Yes ☐ No

IF **YES**, please complete the appropriate supplement application.

3.10 Do you have any other premises or operations exposures not stated in this application? ☐ Yes ☐ No

IF **YES**, enclose complete description and underwriting/rating information.

## PART IV. HISTORY

3.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

| Insurer | Policy Number | Limits of Liability | Premium | Eff. Date | Claims-Made Yes | Claims-Made No |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |

**If claims-made, what is the most recent retroactive date?**_____

3.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

| Insurer | Policy Number | Limits of Liability | Premium | Eff. Date | Claims-Made Yes | Claims-Made No |
|---|---|---|---|---|---|---|
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |

**If claims-made, what is the most recent retroactive date?**_____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ☐ Yes ☐ No

IF **YES**, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary)._____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? ☐ Yes ☐ No

IF **YES**, describe the event and indicate the reason for anticipation of a claim._____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Greenhill Insurance Services, LLC. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

**IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.**

| | | |
|---|---|---|
| Date | Applicant | Title |